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ABSTRACT

Behavior therapists view psychopathology differently from dynamically oriented therapists, in that behaviorists are taught to regard symptoms primarily as sets of learned behaviors rather than cues to underlying psychological disorders. Even though there is a split among behaviorists as to which procedure is best to follow, there are some special strengths of the behavioral viewpoint: (1) because it is a new method, it generates enthusiasm, hope and faith from patients; (2) because it paints a consistent picture of the etiology of all psychopathology, behaviorism obviates the need for wrestling with conflicting dynamic or biological views of the case; (3) diagnosis is linked with treatment, and achievement of goals and depends on a problem solving diagnostic laboratory; and (4) because of this laboratory method, behaviorists are very receptive to research. Limitations of behaviorism include: (1) one procedure cannot cure all ailments; and (2) behavioral procedures have not been useful in treatment of schizophrenia or other functional psychoses. (KJ)

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# THE NEW THERAPIES AND PSYCHOPATHOLOGY: THE BEHAVIORAL VIEWPOINT

Every clinical psychologist worth his shingle knows that behavior therapists view psychopathology differently from dynamically-oriented therapists. To begin with, behaviorists are taught to regard symptoms primarily as sets of learned (albeit maladaptive) behaviors, while dynamicists think of them largely as cues to some underlying psychological disorder. The practical effect of this distinction is that behavior therapists consider their primary treatment goal to be alteration, or if possible, elimination of symptoms; their dynamic brothers, by contrast, consider that they must also root out the underlying causes of these symptoms or else the same symptoms or different ones will reappear. This issue of symptom-substitution, like many other current issues in psychology, has generated much more heat than light. Thus, the behaviorists publish empirical study after empirical study demonstrating that symptom-substitution rarely, if ever, actually occurs, while the dynamicists publish case history after case history proving that it always does. It's a pity that neither read the others' journals; or if they do, they don't believe them.

Even the seemingly simple question of the treatment goals of behaviorists is not a simple one, because these goals differ with the kind of behavior therapy one does. One might choose, for example, to do systematic desensitization--the set of procedures also called reciprocal inhibition by Joseph Wolpe--or aversive conditioning--the paradigm much beloved by experimental psychologists in their torture of rats, also used by certain behaviorists to torture alcoholics and others. The goal of these classical conditioning therapies is extinction of unwanted, maladaptive behavior, be it pervasive anxiety or incessant drug-taking. Broadly, this goal is achieved by altering either the environment or the individual so that the unconditioned and conditioned stimuli whose regular pairing maintains the unwanted behavior no longer coexist. Though operant conditioning techniques (such as assertive training) are frequently used along

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with classical procedures such as systematic desensitization to "build in" new behavioral responses, the goal of the classical conditioning therapies remains elimination of unwanted behaviors.

In contrast to the goals of the classical conditioning therapies--systematic desensitization and aversive conditioning--the goals of the operant conditioning therapies lie as much in the generation and strengthening of new, more adaptive behaviors as they do in the extinction of unwanted ones. The widest application of these procedures is toward management of psychotic patients (following the initial work of Ayllon) and to efforts to shape the behavior of autistic children along more socially responsive lines (as in the work of Lovass). In both applications, the goal of intervention is the gradual "shaping" of behavior, within the operant conditioning paradigm, from unacceptable and often socially disruptive forms to a level within society's relatively narrow limits of tolerance.

Every current first-year graduate student also learns, usually as part of the preparation for his preliminary exams, that behavioral treatment involves the judicious application of appropriate conditioning procedures, while insight therapy requires lengthy and thoughtful dredging up of the memorial traces of early psycholocial traumas. What first-year graduate students do not often learn in time for prelims is that, despite genuine and convincing differences in their views of what constitutes the right way to do treatment, dynamic and behavioral therapists often reach strikingly similar ends with their diverse methods. While this has been recognized for some time by therapists of different theoretical persuasion within the dynamic camp, the behaviorists cannot even agree among themselves on the best way to do <u>behavior</u> therapy. To that end, a bitter struggle is currently in progress within the behavioral camp between the proponents of the monolithic view of behavior therapy who see value only in "orthodox" systematic desensitization (the "classical" model) and those who

espouse the "broad spectrum behavior therapy" view which includes systematic desensitization and the various operant techniques within its therapeutic armamentarium. The recent founding of two new behavior journals reflects as much on this split in the heretofore solid ranks of the behaviorists as it does the new popularity of these procedures.

Since I am billed as being the behaviorists' representative at this meeting, let me now continue by pointing out some of the special strengths of the behavioral viewpoint in the clinic. In the first place, just by virtue of their providing new approaches to an old problem, the behavior therapies generate much enthusiasm and commitment from their adherents and much hope and faith from patients on whom they are tried. As a consequence, their "cure" rates are probably higher now than they will be after the initial "bloom on the rose" has worn off and they cannot call upon the novelty factor (the "Hawthorne effect") as an adjunct to therapeutic effort.

More seriously, the behavioral view of psychopathology, because it paints a consistent picture of the etiology of all psychopathology, obviates the need for clinician or patient to wrestle with conflicting dynamic or biological views of cause. All therapists of dynamic bent remember neurotic patients, the major form of whose "resistance" took the form of elaborate reflection on which parent or sib, which teacher or coach, which girl- or boyfriend, which of several traumas at age three, were responsible for which portion of the present neurosis. And everyone who has ever tried to talk about their illness to bright schizophrenics in partial remission knows their predilection for debate on the relative merits of the serotonim or taraxein theories of the etiology of schizophrenia. By contrast, behaviorists tend to assert simply that these conditions exist largely because of maladaptive learning--learning which, while at one time it may have been appropriate and useful, is no longer so. Though it is true that many behaviorists remain uncertain as to whether or not

schizophrenia has a biological determinant, and it is also true that behaviorists do not always agree on exactly how a particular sequence of maladaptive learning took place, behaviorists do agree that many symptoms seen at a later stage of an individual's development came about as previously learned responses to now-changed environmental circumstances. The significance of such a view for behaviorists' conceptualizations of psychopathology is fundamental: it requires them to categorize psychopathology by type rather than by etiology, course, or outcome. A number of current APA diagnostic labels are either etiological (e.g., depressive reaction--a psychoneurosis--as against involutional psychotic reaction--a psychosis with similar symptoms) or outcome-oriented (e.g., manic-depressive reaction), a labeling principle of little or no practical merit.

Perhaps the most exciting new development in conceptualizations of psychopathology brought on by the behavioral movement is the view that the summary of psychopathology implicit in formal diagnosis ought also to imply treatment. This view derives from the assumption that the maladaptive behaviors being so described will shortly be subjected to conditioning and new learning based on knowledge of the original conditioning situation. The most profound explication of this point of view was published by Frederick Kanfer in 1965. In Behavioral Analysis, Kanfer proposes a new system of diagnosis derived from a patient's performance in a laboratory setting designed to permit analysis of his ability to solve a variety of laboratory tasks analogous to real life ones. By extension, the proposed laboratory would be a model of a patient's original learning situation; its use as a diagnostic vehicle would presumably result in a diagnostic formulation directly linked to treatment for the problem-solving difficulties.

Discussion of the concept of diagnosis extricably linked with treatment--and achievement of this goal via a "problem-solving" diagnostic laboratory--

permit easy transition to discussion of the final, perhaps major, strength of the behavioral movement in clinical psychology. Because both behavior therapy and behavior modification derive largely from the experimental psychology laboratory, their early adherents were usually laboratory-trained experimental clinicians. This is certainly true of the earliest behavior modifiers, Lindsley and Ferster, both of whom were students of experimental psychology with Skinner. It is also true of the behavior therapists who trained with Eysenck at the University of London. Because these men came from a strongly data-oriented tradition, they have tended to demand empirical confirmation for claims of the efficacy of their procedures. For this reason, the behavioral therapists seem to have amassed more empirical evidence of the limits of the applicability of their procedures--and offer correspondingly more opportunities for such evaluation--than the dynamic therapists. Though there are notable exceptions to this rule, especially among the major systematic desensitizers, this receptivity to research is certainly a strength of the behavioral movement that ought not be forgotten.

It is time now to move on to consideration of the limits of applicability of the behavior therapies, limits often established on empirical bases. Here, too, there are conflicting views on the matter. Certain limited and now archaic systematic desensitizers believe that their procedures (assertive and relaxation training in conjunction with desensitization of anxiety- or fear-provoking images) are useful for all conditions, including the psychoses. Other equally naive behavior modifiers think that their procedures can permanently cure certain psychotic conditions. My own view of the matter, based on personal experience and on evaluation of research findings, is more moderate. I think that systematic desensitization has proven its value in the treatment of conditions involving circumscribed anxiety. Aversive conditioning, also a classical conditioning method, has been of value in treatment of "personality

disorders" characterized by antisocial or antiself behaviors, including alcoholism, the addictions, and the several disorders of sexual functioning. These methods have not been useful in treatment of the schizophrenias or the other functional psychoses.

The various (operant) behavior modification techniques have been of great value in the institutional treatment of severely regressed psychotic patients, to whom they offer a chance for a much more pleasant existence within the mental hospital milieu. These methods have not so far been responsible for returning many schizophrenics to society, though they may yet have this potential. The behavior modification procedures have also helped Lovass attenuate autistic symptoms while teaching schizophrenic children to speak and to relate interpersonally. Wolf, Baer, Lindsley, and others have used operant methods, centering on manipulation of social rewards, in the classroom to enhance learning.

Professor Brodsky, in organizing this program, asked each symposium participant to discuss the implications for training that his particular "new therapy" has. He suggested in a letter that certain of the "new therapies" might now deemphasize the degree to which the student actually becomes involved with his patient while emphasizing certain of the "technological" aspects of treatment (as in computer-assisted delivery of reinforcement). I suspect that Professor Brodsky had me rather than Dr. Greenwald in mind when he asked for this matter to be discussed.

The fact is, though, that unless the therapist becomes involved with his patient, at least to the extent of spending time observing his naturally occurring behavior if he plans to do behavior modification, or sitting down with him to construct realistic and valid hierarchies of fear-or anxiety-producing stimuli if he plans systematic desensitization, he will not succeed in the therapy. I have always felt that psychoanalysts who accelerate their

patients' transference distortions, and marathon group therapists who generate countertransference phenomena, both for "therapeutic gain," are behaving just like behaviorists who talk of using themselves as major reinforcement vehicles (as in "transference") and helping the patient alter his behavior so that he will reinforce rather than punish society for its appropriate behavior to him (this is "countertransference"). We teach our students at Rutgers first to establish a positive relationship with all patients--in behavioral terms, to structure things so that they serve as either positive reinforcers themselves or at least as signals for positive reinforcement--before attempting to alter behavior by any means. That is, they are taught that no therapy can take place before the patient is prepared to accept it.

To summarize, I am content to quote the unknown author of Ecclesiastes, who said, among other things, "The thing that hath been, it is that which shall be; and that which is done is that which shall be done: and there is no new thing under the sun" (1:9).

P. E. Nathan
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